1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09497 Item #2d Film #G391 6711/67 ph

CERTIFICATE OF DEATH

09498

1. PLACE OF DEATH
a. COUNTY: DORCHESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE
c. LENGTH OF STAY IN 1b: 1 mon. 5 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): EASTERN SHORE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: DORCHESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE 09.1
d. STREET ADDRESS: 103 Phillips Ave. Gladstone Bldg. / HOME
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

13

I

3. NAME OF DECEASED (Type or print): First: DELLA — Middle: D. — Lost: Adams

4. DATE OF DEATH: Month: July — Doy: 29 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 01-19-86

9. AGE (In years lost birthday): 81 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (County & Stote, or foreign country): Dorchester, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robinson Delaha

14. MOTHER'S MAIDEN NAME: Mary Jane Sellers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 214-07-7318A

17. INFORMANT Address: EASTERN SHORE State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (o)	CONGESTIVE HEART FAILURE	2 DAYS
DUE TO (b)	PNEUMONIA	15 DAYS
DUE TO (c)	CANCER OF BREAST C METASTASIS TO THE LUNG	10+ YRS.

170X

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o): GENERALIZED ARTERIOSCLEROSIS C CHRONIC BRAIN SYNDROME

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, affice bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from 24 JUNE, 1967, to 29 JULY, 1967, that (I) (we) last saw the deceased alive an 29 JULY 1967, ond that death occurred ot 9 00 AM, from causes and on the date stoted above.

22o. SIGNATURE: Sean M Killoran — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 29 July 1967

22c. PHYSICIAN'S NAME (Type): SEAN M. KILLORAN M.D.

22d. ADDRESS: BOX 291 WALTER REED GEN HOSP WASHINGTON DC.

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 31, 1967

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial

23d. LOCATION (City or Town) (County) (Stote): Park Cambridge, Md.

24. FUNERAL DIRECTOR: Kenneth K Thomas Jr. — ADDRESS: Cambridge Md.

25o. REG'D BY REGISTRAR DATE: AUG 4 1967

25b. REGISTRAR'S SIGNATURE: James Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09498 09499

1. PLACE OF DEATH
a. COUNTY: Dorchester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge-Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 604 Academy Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Middle: Levin Last: Adams

4. DATE OF DEATH: Month: July Day: 30 Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 3, 1905

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Golden Hill, Dorchester

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Quincy Adams

14. MOTHER'S MAIDEN NAME: Anna Jarrett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: 604 Academy St.
Mrs. Helen T. Adams, Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): METASTATIC CARCINOMA TO BRAIN — INTERVAL BETWEEN ONSET AND DEATH: 3+ WEEKS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CARCINOMA of LARYNX — 1+ YEAR
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-30, 1967, to 7-30, 1967, that (I) (we) last saw the deceased alive on 7-30 1967, and that death occurred at 10:15 M, from the causes and on the date stated above.

22a. SIGNATURE: James F. McCarter M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-31-67

22c. PHYSICIAN'S NAME (Type): JAMES F. McCARTER

22d. ADDRESS: Box 386 CAMBRIDGE, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 2, 1967

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park, Cambridge, Md.

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR: Kenneth R. Thomas

ADDRESS: Cambridge, Md.

25a. REC'D BY REGISTRAR DATE: AUG 4 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09499

CERTIFICATE OF DEATH

09500

1. PLACE OF DEATH
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
   c. LENGTH OF STAY IN 1b: 2 hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge Maryland Hospital, Inc.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Dorchester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
   d. STREET ADDRESS: 808 Phillips Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Allen

4. DATE OF DEATH: Month: July — Day: 25 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 24, 1967

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours: 2 — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Dorchester Co. Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Charles Neal Jr.

14. MOTHER'S MAIDEN NAME: Malinda Ann Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mother — Address: Same As Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Marked Premature
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
776X

INTERVAL BETWEEN ONSET AND DEATH: 2 Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 24, 19 67, to July 25, 1967, that (I) (we) last saw the deceased alive on July 24, 19 67, and that death occurred at 12:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Dr. J. Edwin Fassett — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-1-67

22c. PHYSICIAN'S NAME (Type): Dr J. Edwin Fassett

22d. ADDRESS: 623 High Street Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 7/25/67

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR — ADDRESS: Virginia Skinner R.N. Cambridge Md. Hospital

25a. REC'D BY REGISTRAR DATE: AUG 2 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09500 09501

1. PLACE OF DEATH
a. COUNTY: Dorchester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salem
c. LENGTH OF STAY IN 1b: 46 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Dor.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salem
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ernest Middle: Tredway Last: Banning
4. DATE OF DEATH: Month: 7 Day: 28 Year: 1967
5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/20/1898
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Post-Master - Salem
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland, Dorchester
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William T. Banning
14. MOTHER'S MAIDEN NAME: Bernice Collison
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown):
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs E. T. Banning, Salem, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS
332 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES M.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/3, 1962, to 7/28, 1967, that (I) (we) last saw the deceased alive on 7/26 1967, and that death occurred at 7 A M, from the causes and on the date stated above.

22a. SIGNATURE: W. E. Gumby Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/28/67
22c. PHYSICIAN'S NAME (Type): W. E. GUMBY JR.
22d. ADDRESS: CAMBRIDGE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/30/67
23c. NAME OF CEMETERY OR CREMATORY: East New Market
23d. LOCATION (City, town or county) (State): East New Market Md
24. FUNERAL DIRECTOR: Ruth D. Tilloughby ADDRESS: East New Market Md
25a. REC'D BY REGISTRAR: JUL 31 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09501

CERTIFICATE OF DEATH

09502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Cambridge Maryland Hospital

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Dorchester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Cambridge
   d. STREET ADDRESS: Arcade Apartments
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: JESSE — Middle: M. — Lost: BRADLEY, Jr.

4. **DATE OF DEATH**: Month: July — Day: 16 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: Jan. 28, 1893

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plant Foreman-Retired

10b. KIND OF BUSINESS OR INDUSTRY: Food Canning

11. BIRTHPLACE (County & State, or foreign country): Cambridge, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jesse M. Bradley

14. MOTHER'S MAIDEN NAME: Mary Sollaway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: unk

17. **INFORMANT** — Address: Mr. Michael Bradley, Cambridge, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): EMPHYSEMA — INTERVAL BETWEEN ONSET AND DEATH: 6 YEARS
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b):
   DUE TO
   (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CHRONIC BRONCHITIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor / Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/13, 1967, to 7/16, 1967, that (I) (we) last saw the deceased alive on 7/15, 1967, and that death occurred at 7:45 A.M., from causes and on the date stated above.

22a. SIGNATURE: W.E. Gunby Jr. M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 7/18/67

22c. PHYSICIAN'S NAME (Type): W.E. GUNBY JR.

22d. ADDRESS: Cambridge Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 19 1967

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park

23d. LOCATION (City or Town) (County) (State): Cambridge, Maryland

24. FUNERAL DIRECTOR — ADDRESS: LeCompte Funeral Service, Cambridge, Maryland

25a. REC'D BY REGISTRAR: JUL 21 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09502 09503

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hurlock
c. LENGTH OF STAY IN 1b: Few WKs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Belle Haven Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE: Md b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hurlock
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Susie Middle: Crumpler Last: Bradley

4. DATE OF DEATH Month: 7 Day: 14 Year: 1967

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/21/1891

9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Crumpler

14. MOTHER'S MAIDEN NAME: Ada Edwards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Merton Bradley Jr. Address: Hurlock, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinomatois — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

1538

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Adeno carcinoma of th Colen — 1964

DUE TO (c) Resection of the above in 1964

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mild Cerebro vacularaccident 5 days Chronic Haert failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/9/66, 19__, to 7/14/66, 19__, that (I) (we) last saw the deceased alive on 7/11/ 19 67, and that death occurred at 2:45 M from the causes and on the date stated above.

22a. SIGNATURE [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/14/67

22c. PHYSICIAN'S NAME (Type): Harold B. Plummer M.D.

22d. ADDRESS: Preston Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/16/67

23c. NAME OF CEMETERY OR CREMATORY: Washington

23d. LOCATION (City, town or county): Hurlock (State): Md

24. FUNERAL DIRECTOR: Ruth S. Willoughby, ADDRESS: East New Market

25a. REC'D BY REGISTRAR DATE: JUL 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Grogg

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09503

CERTIFICATE OF DEATH

09505

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: DORCHESTER — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CAMBRIDGE MARYLAND HOSPITAL, INC.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: DORCHESTER
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EAST NEW MARKET
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: SARAH — Middle: ELIZABETH — Last: CAMPER

4. **DATE OF DEATH**: Month: JULY — Day: 11 — Year: 19 67

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY 22, 1922

9. AGE (In years last birthday): 44 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (County & State, or foreign country): DORCHESTER CO., MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRED JACKSON

14. MOTHER'S MAIDEN NAME: EDITH STANLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
   (If yes give war or dates of service): -----

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: MINNIE JACSON — Address: EAST NEW MARKET, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Hepatic Coma — INTERVAL BETWEEN ONSET AND DEATH:
   DUE TO (b): Fatty degeneration of liver — 3 days
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (c):

   5810

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 8, 19 67 to July 11, 19 67 that (I) (we) last saw the deceased alive on July 11, 19 67, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: J. Edwin Fassett

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/14/67

22c. PHYSICIAN'S NAME (Type): J. EDWIN FASSETT, M.D.

22d. ADDRESS: 623 HIGH STREET CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/15/67

23c. NAME OF CEMETERY OR CREMATORY: EAST NEW MARKET

23d. LOCATION (City or Town) (County) (State): EAST NEW MARKET DOR. MD.

24. FUNERAL DIRECTOR: Frederick C. Atkins — ADDRESS: CAMBRIDGE, MD.

25a. REC'D BY REGISTRAR DATE: JUL 17 1967

25b. REGISTRAR'S SIGNATURE:

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09504

CERTIFICATE OF DEATH

09506

1. **PLACE OF DEATH**
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge-Maryland Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Queen Anne
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chester
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ernest — Middle: — Last: Chew

4. **DATE OF DEATH**: Month: 7 — Day: 29 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 12, 1896

9. AGE (In years last birthday): 71 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Howard, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213-05-4290A

17. **INFORMANT**: Virginia Turner — Address: Chester, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary heart disease
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b):
   DUE TO
   (c):
   INTERVAL BETWEEN ONSET AND DEATH: 1 week

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 30, 19 67, to July 29, 19 67, that (I) (we) last saw the deceased alive on July 29, 19 67, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: August 1, '67

22c. PHYSICIAN'S NAME (Type): Dr. J. Edwin Fassett

22d. ADDRESS: 623 High Street, Camb., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-3-67

23c. NAME OF CEMETERY OR CREMATORY: Batts Neck

23d. LOCATION (City or Town) (County) (State): Queen Anne's Md.

24. FUNERAL DIRECTOR: G. H. Dashiell — ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: AUG 4 1967

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09505 — 09507

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Dorchester. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Cambridge
   c. LENGTH OF STAY IN 1b: 3 mo.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Eastern Shore State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Somerset
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield Box 345
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Mayne — Middle: A. — Last: Collins

4. **DATE OF DEATH**: Month: July — Day: 6 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-9-84

9. AGE (In years last birthday): 83 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Public Schools

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Henry Cullen

14. MOTHER'S MAIDEN NAME: Jane Sterling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 215-18-4800

17. **INFORMANT** Medical Records Address: Eastern Shore State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Senile cachexia — INTERVAL BETWEEN ONSET AND DEATH: 1 year
   794X
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b):
   DUE TO
   (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-14-67, 19__ to 7-6, 1967 that (I) (we) last saw the deceased alive on July 6 1967, and that death occurred at 11:55 PM, from causes and on the date stated above.

22a. SIGNATURE: Carlos F Barroso — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-7-1967

22c. PHYSICIAN'S NAME (Type): CARLOS F. BARROSO

22d. ADDRESS: Hurlock Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: July 9, 1967

23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

23d. LOCATION (City or Town) (County) (State): Crisfield, Md.

24. FUNERAL DIRECTOR: Bradshaw and Sons — ADDRESS: Crisfield

25a. REC'D BY REGISTRAR DATE: JUL 11 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09506

CERTIFICATE OF DEATH

09503

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Dorchester
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Fishing Creek
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEROY Middle COMPTON Last

4. DATE OF DEATH: Month July Day 12 Year 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 30, 1899
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plant Manager
10b. KIND OF BUSINESS OR INDUSTRY: Seafood Dehydrating
11. BIRTHPLACE (County & State, or foreign country): Green Creek, New Jersey
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel S. Compton
14. MOTHER'S MAIDEN NAME: Lizzie Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: unk
17. INFORMANT: Mrs. Leroy Compton, Address: Fishing Creek, Md. 21634

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO (b): Arteriosclerotic CVD — 2 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Aortic Stenosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-23, 1967 to 7-12 1967 that (I) (we) last saw the deceased alive on 7-12 1967, and that death occurred at 3:45 M, from causes and on the date stated above.

22a. SIGNATURE: W Bauman M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-14-67
22c. PHYSICIAN'S NAME (Type): W. N. Bauma nn, M.D.
22d. ADDRESS: Cambridge, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 16 1967
23c. NAME OF CEMETERY OR CREMATORY: Old Trinity Churchyard
23d. LOCATION (City or Town) (County) (State): Church Creek, Maryland

24. FUNERAL DIRECTOR ADDRESS: LeCompte Funeral Service, Cambridge, Maryland
25a. RECD BY REGISTRAR DATE: JUL 17 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09507

CERTIFICATE OF DEATH

09509

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CAMBRIDGE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): CAMBRIDGE

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MD. — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~CAMBRIDGE~~ Church Creek
d. STREET ADDRESS: C
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: JOHN — Middle: HENRY — Last: DIXON

4. DATE OF DEATH: Month: 7 — Day: 1 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12-12-1899

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): MADISON, MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN DIXON

14. MOTHER'S MAIDEN NAME: MARY KING

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-30-0854

17. INFORMANT: HELEN DIXON — Address: CHURCH Cre

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 14 days
DUE TO (b): Coronary Heart Disease — 1 yr.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/18/67, 19..., to 7/1/67, 19..., that (I) (we) last saw the deceased alive on 7/1/67 19..., and that death occurred at 10:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Lawrence Maryanov M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/3/67

22c. PHYSICIAN'S NAME (Type): Lawrence Maryanov

22d. ADDRESS: Cambridge, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Madison Cemetery

23d. LOCATION (City, town or county) (State): Madison Md

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Booker M. West 718 Pine St Cambridge Md

25a. REC'D BY REGISTRAR DATE: JUL 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09508 09510

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: DORCHESTER	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE: MARYLAND b. COUNTY: DORCHESTER
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CAMBRIDGE c. LENGTH OF STAY IN 1b: LIFE	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE 09.1
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): CAMBRIDGE MARYLAND HOSPITAL, INC.	d. STREET ADDRESS: DUNNS LANE e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
WILLIAM	DELORNE	EDWARDS	JULY	4	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	NEGRO		DEC. 20, 1928	38 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	-----	DORCHESTER CO., MD.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JAMES EDWARDS	JULIA STEWARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES		VENETTE PHELPS CAMBRIDGE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular accident

443x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive C.V.D.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 15, 1967 to July 4, 1967, that (I) (we) last saw the deceased alive on July 4, 1967, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE	M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
J. Edwin Fassett		July 6, 1967

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
J. EDWIN FASSETT, M.D.	623 HIGH STREET CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	7/8/67	BETHEL	CAMBRIDGE, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Frederick C. Dukes	CAMBRIDGE, MD.	JUL 17 1967	J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09509

CERTIFICATE OF DEATH

09511

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: DORCHESTER — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE
   c. LENGTH OF STAY IN 1b: 20 YRS.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 615 HUBERT STREET

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: DORCHESTER
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE
   d. STREET ADDRESS: 615 HUBERT STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: JOHN — Middle: WILLIAM — Lost: FERBY, JR.

4. **DATE OF DEATH**: Month: JULY — Day: 26, — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: NEGROID

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 1, 1920

9. AGE (In years last birthday): 47 yrs.
   IF UNDER 1 YEAR — Months / Days
   IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (County & State, or foreign country): ACCOMAC CO., VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN WILLIAM FERBY, SR.

14. MOTHER'S MAIDEN NAME: BERTHA B. FERBY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
    (If yes give wor or dotes of service): --------

16. SOCIAL SECURITY NO.: 213-16-8041

17. **INFORMANT**: FANNIE FERBY — Address: CAMBRIDGE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Carcinoma of the lungs
    DUE TO (b):
    DUE TO (c):
    Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
    163 X
    INTERVAL BETWEEN ONSET AND DEATH: 2 mons.

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 5, , 19 67, to July 26, 19 67, that (I) (we) last saw the deceased alive an July 26, 19 67, and that death accurred at ____ M, fram causes and an the date stated abave.

22a. SIGNATURE: J. Edwin Fassett

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: July 26, '67

22c. PHYSICIAN'S NAME (Type): J. EDWIN FASSETT, M.D.

22d. ADDRESS: 623 HIGH STREET CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/29/67

23c. NAME OF CEMETERY OR CREMATORY: BETHEL

23d. LOCATION (City or Town) (County) (State): CAMBRIDGE DOR. MD.

24. FUNERAL DIRECTOR: Frederick C. Dyer

ADDRESS: CAMBRIDGE, MD.

25a. REC'D BY REGISTRAR DATE: AUG 7 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

1-3

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09510

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09512

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: about 30yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 409 Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First J. — Middle BALDWIN — Last FITZHUGH

4. DATE OF DEATH: Month July — Day 21 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 23, 1888

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Horse Trainer

10b. KIND OF BUSINESS OR INDUSTRY: Race Horse

11. BIRTHPLACE (State or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Fitzhugh

14. MOTHER'S MAIDEN NAME: Susie Adkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): - - -

16. SOCIAL SECURITY NO.: unk

17. INFORMANT: Mrs Richard Insley, Woolford, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
H201
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace M.D.

EXAMINER'S NAME (Type): John Mace Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED: 7/22/67 Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 24 1967

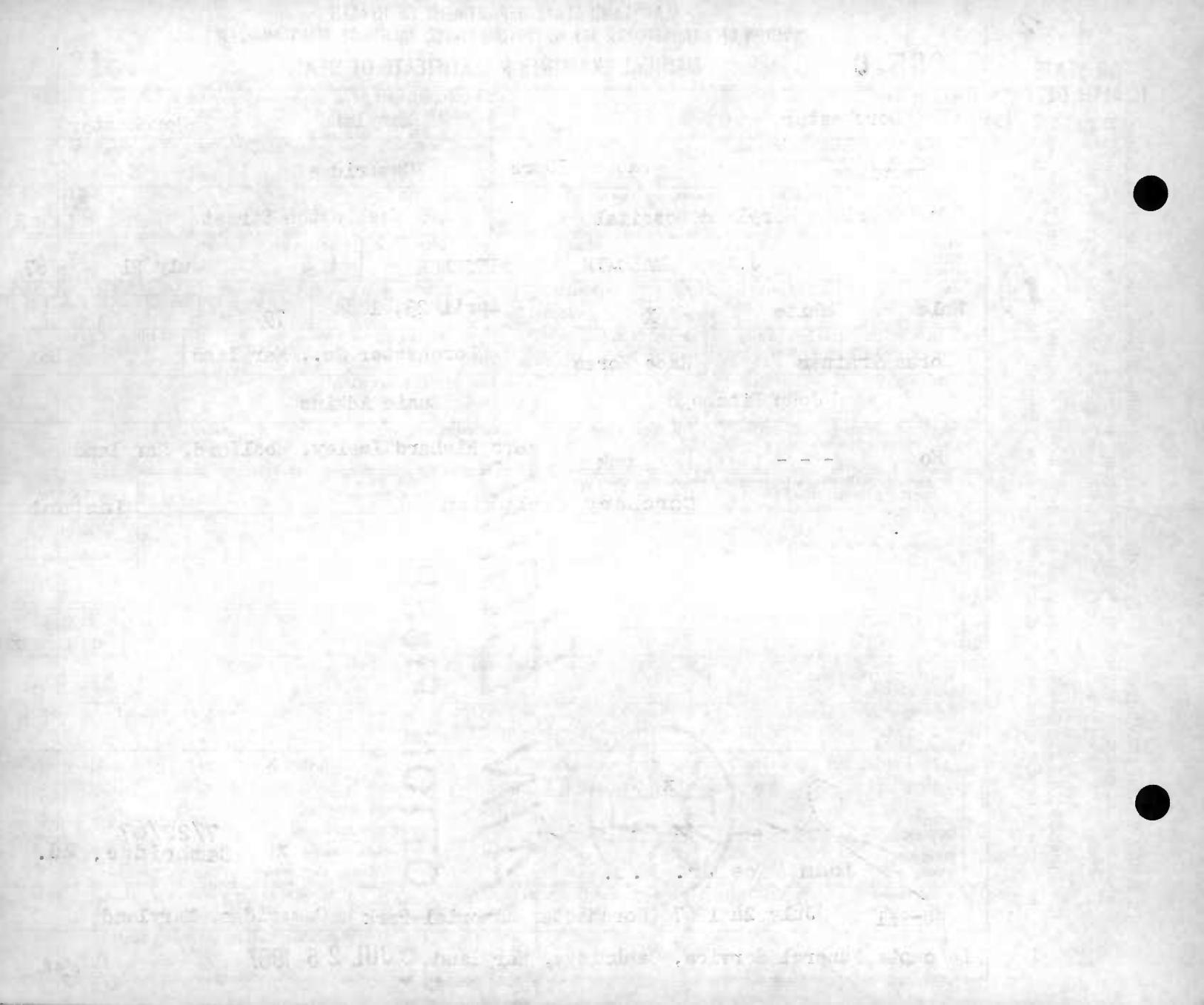
23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park

23d. LOCATION (City or Town) (County) (State): Cambridge, Maryland

24. FUNERAL DIRECTOR: LeCompte Funeral Service, Cambridge, Maryland — ADDRESS

25a. REC'D BY REGISTRAR DATE: JUL 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge



FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09511 Item #9 Film #G391 8/4/67 ph 09513

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 00 Bayly Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Ridgely, Md.
d. STREET ADDRESS: 25[illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Christopher — Middle: Columbus — Last: Flamer

4. DATE OF DEATH: Month: July — Day: 20 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: N

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 3, 1966 2

9. AGE (In years last birthday): 43 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Chicken plant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Victor Flamer

14. MOTHER'S MAIDEN NAME: Lillie Hines

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give wer or dates of service): WWll

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. C.C.Flamer, Hillsboro, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
4301
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): John Mace Jr. M.D.

DATE SIGNED: 7/27/67

Address (Street, city, town, or county): Cambridge, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July261967

22c. NAME OF CEMETERY OR CREMATORY: Sandtown

22d. LOCATION (City, town, or country) (State): Hillsboro, Md.

23. FUNERAL DIRECTOR — ADDRESS: Charles V. Moore, Denton, Md.

24a. REC'D BY REGISTRAR DATE: JUL 31 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09512

CERTIFICATE OF DEATH

09514

1. PLACE OF DEATH
a. COUNTY: DORCHESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge, Md.
c. LENGTH OF STAY IN 1b: 7 Mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glasgow Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Vienna
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nettie — Middle Cleveland — Last Foxwell

4. DATE OF DEATH: Month July — Day 22 — Year 1967

5. SEX: F

6. COLOR OR RACE: Wh.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 19 1885

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house work

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Dorchester, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Foxwell

14. MOTHER'S MAIDEN NAME: Alice Hurley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 219-01-4729

17. INFORMANT: Shirley Smith — Address: 202 Choptank Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRO VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 15 MINUTES
331X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): CEREBRAL THROMBOSIS
DUE TO (c): CEREBRAL ATHERESCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): HYPERTENSION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-26, 1966, to 7-22, 1967, that (I) (we) last saw the deceased alive on 7-17 1967, and that death occurred at 10 A M, from the causes and on the date stated above.

22a. SIGNATURE: Richard S. Bilodeau M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-22-67

22c. PHYSICIAN'S NAME (Type): RICHARD G. BILODEAU, M.D.

22d. ADDRESS: 116 OAKLEY ST. CAMBRIDGE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/24/67

23c. NAME OF CEMETERY OR CREMATORY: East New Market

23d. LOCATION (City, town or county) (State): East New Market, Md

24. FUNERAL DIRECTOR: Ruth S. Willoughby — ADDRESS: East New Market

25a. REC'D BY REGISTRAR DATE: JUL 27 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
20M 1/65

Jno Young

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09513 09515

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rhodesdale - Rural
   c. LENGTH OF STAY IN 1b: 2 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Near Wesley Church

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Ohio
   b. COUNTY: Richland
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Mansfield
   d. STREET ADDRESS: 615 Carlisle Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS; Middle; Last GARRETT

4. DATE OF DEATH: Month July; Day 1; Year 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ Unknown DIVORCED ☐

8. DATE OF BIRTH: May 4, 1918

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cement Finisher

10b. KIND OF BUSINESS OR INDUSTRY: Concrete

11. BIRTHPLACE (State or foreign country): Cincinnati, Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wayne Garrett

14. MOTHER'S MAIDEN NAME: Mary Hunter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 270-12-5646

17. INFORMANT: Mrs. Florence Hunter, Address: Hill St., Somerset, Ky.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive subarachnoid
DUE TO (b): Hemorrhage
DUE TO (c): ruptured aneurysm of basilar artery
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 330 X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Peter W. Rieckert M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Peter W. Rieckert E-Nanticoke Md
Address (Street or box, town or county)

22. DATE SIGNED: 7-1-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 18, 1967

23c. NAME OF CEMETERY OR CREMATORY: Rhodesdale Cemetery

23d. LOCATION (City or Town) (County) (State): Near Rhodesdale, Maryland

24. FUNERAL DIRECTOR ADDRESS: J. J. Frampton and Son, Fredericksburg, Maryland — Jerome Frampton Jr.

25a. REC'D BY REGISTRAR DATE: JUL 20 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09514

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09516

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glasgow Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Queen Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): unk
d. STREET ADDRESS: Unk
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JAMES — Middle — Last GILLIAN
4. DATE OF DEATH: Month July — Day 23 — Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ unk DIVORCED ☐
8. DATE OF BIRTH: Oct. 1, 1889
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unk
10b. KIND OF BUSINESS OR INDUSTRY: unk
11. BIRTHPLACE (State or foreign country): Queen AnneCo., Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: unk
14. MOTHER'S MAIDEN NAME: unk
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unk — (If yes give war or dates of service): unk
16. SOCIAL SECURITY NO.: unk
17. INFORMANT — Address: Glasgow Nursing Home, Cambridge, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO XX

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection [X], Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.
EXAMINER'S NAME (Type): ~~EXAMINER~~ John Mace Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)
22. DATE SIGNED: 7/24/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 26 1967
23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery
23d. LOCATION (City or Town) (County) (State): Cambridge, Maryland

24. FUNERAL DIRECTOR — ADDRESS: LeCompte Funeral Service, Cambridge, Maryland
25a. REC'D BY REGISTRAR — DATE: JUL 28 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09515 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09517

Items 8 & 9 Film 0392 8/24/67 kk

1. PLACE OF DEATH
a. COUNTY: DORCHESTER MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE
c. LENGTH OF STAY IN 1b: 2DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.F.D. 2

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: DEL. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
d. STREET ADDRESS: RT. 3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First DINEL Middle — Last GRAY
4. DATE OF DEATH: Month 7 Day 28 Year 1967
5. SEX: M
6. COLOR OR RACE: BLACK
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: September 22, 1966
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months 10 Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Seaford, Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ROBERT MOLLOCK
14. MOTHER'S MAIDEN NAME: ANITA GRAY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: ROBERT MOLLOCK - LAUREL DEL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): SUB DURAL HEMATOMA — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c):
391.2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): BILATERAL OTITIS MEDIA
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. ? Month, Day, Year ? 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ?
20f. (City or town) (County) (State): UNKNOWN

21. I certify that I took charge of the remains described above, held an Autopsy [X] Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [X]

ACTUAL SIGNATURE: John Mace Jr. M.D.
EXAMINER'S NAME (Type): JOHN MACE JR.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [ ]
Address (Street, city, town, or county):
DATE SIGNED: 7/28/67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/30/67
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
22d. LOCATION (City, town, or country): Cambridge (State): Md

23. FUNERAL DIRECTOR ADDRESS: Herbert M. St. Clair, Jr. Cambridge, Md
24a. REC'D BY REGISTRAR DATE: AUG 7 1967
24b. REGISTRAR'S SIGNATURE: Charles Yeager

VR A15ME
5M 1/62

6-46

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09516 09518

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages (1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: Few days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge Maryland

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Dor.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East New Market
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emerson — Middle: Woodrow — Last: Henry

4. DATE OF DEATH: Month: 7 — Day: 25 — Year: 1967

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/12/1914

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): St. Hospital Employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Dor. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard I Henry

14. MOTHER'S MAIDEN NAME: Eva Marine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs Emerson Henry, East New Market

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis — 1 yr
DUE TO (c):
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-21-67, 19__, to 7-25, 1967, that (I) (we) last saw the deceased alive on 7-25 1967, and that death occurred at 3:35 M, from the causes and on the date stated above.

22a. SIGNATURE: W. Baumann M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/25/67

22c. PHYSICIAN'S NAME (Type): Wilbur N. Baumann

22d. ADDRESS: Cambridge, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/27/67

23c. NAME OF CEMETERY OR CREMATORY: East New Market

23d. LOCATION (City, town or county) (State): East New Market, Md.

24. FUNERAL DIRECTOR: Ruth S. Willoughby — ADDRESS: East New Market

25a. REC'D BY REGISTRAR DATE: JUL 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09517 — 09519

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Cambridge-Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge - Rural
d. STREET ADDRESS: R.F.D. #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	IDA	LILLIAN	HIGGINS		July	10	1967

5. SEX	6. COLOR OR RACE	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White		Sept. 20, 1890	76 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Home	Dorchester Co., Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John W. Moore	Rosa Cheeseman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		218-48-5532	H. Jerome Higgins, Cambridge, Md., RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Arteriosclerotic Nephritis	3 months
DUE TO (b)	Arteriosclerotic gangrene of Lower extremities	3 months
DUE TO (c)	Diverticulosis of lower intestinal tract & Hernia	3 months

5721

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/7/67, 19__ to 7/10/67, 19__, that (I) (we) last saw the deceased alive on 7/9/67 19__, and that death occurred at 7:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: Lawrence Maryanov — M.O. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED: 7/13/67

22c. PHYSICIAN'S NAME (Type): Lawrence Maryanov — 22d. ADDRESS: 610 Race St. Cambridge, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	July 12, 1967	East New Market Cemetery	East New Market, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. J. Frampton and Son	Federalsburg, Maryland	JUL 17 1967	J. Charles Jones

VR A15 (4) 20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09518 09520

1. PLACE OF DEATH
a. COUNTY: Dorchester MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Cambridge-Md. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge 09.1
d. STREET ADDRESS: 206 Glenburn Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edwin Middle Cornelius Last HopkinsJr.
4. DATE OF DEATH: Month July Day 11 Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb.3,1898
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): V.P. of Sales
10b. KIND OF BUSINESS OR INDUSTRY: Canning
11. BIRTHPLACE (County & State, or foreign country): Dorchester, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edwin C. Hopkins
14. MOTHER'S MAIDEN NAME: Clara Ewell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 214-07-9307
17. INFORMANT: A Address: Mrs. E.C.Hopkins Jr. Cambridge Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of lung with
DUE TO (b): metastases
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
163 X
INTERVAL BETWEEN ONSET AND DEATH: Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 1, 1967, to July 11, 1967, that (I) (we) last saw the deceased alive on July 11 1967, and that death occurred at 1P M, from the causes and on the date stated above.

22a. SIGNATURE: Lewis M Burdette M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 15 July 67
22c. PHYSICIAN'S NAME (Type): Lewis M. Burdette
22d. ADDRESS: 4 Aurora St, Cambridge Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 13 '67
23c. NAME OF CEMETERY OR CREMATORY: Cambridge Cemetery
23d. LOCATION (City, town or county) (State): Cambridge Md.

24. FUNERAL DIRECTOR: Jerrett R Stokes Jr
ADDRESS: Cambridge Md.
25a. REC'D BY REGISTRAR DATE: JUL 17 1967
25b. REGISTRAR'S SIGNATURE: J Jennings

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09519

CERTIFICATE OF DEATH

09521

1. **PLACE OF DEATH**
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge (rural)
   c. LENGTH OF STAY IN 1b: 2 months
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Eastern Shore State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Talbot
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton, Maryland
   d. STREET ADDRESS: III Goldsborough Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

13

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year 19
Norman	Charles	Jefferson	07-	10-	67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR: Months / Doys	IF UNDER 24 HRS.: Hours / Min.
Male	White		12-20-80	86 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Insurance Agent	Insurance	Delaware	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Henry Jefferson	Margaret Ann Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
unknown	216-03-7477	Records of the Eastern Shore State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia complicating	
DUE TO (b)	arteriosclerotic cardiovascular	
DUE TO (c)	Disease	

491X

Conditions, if ony, which gove rise ta immediate cause (a), stoting the underlying cause lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)			
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased olive an _____ 19___, and that death accurred at 7:30 P. M, fram causes and an the date stated abave.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Peter W. Rieckert		7-11-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Peter W. Rieckert	E. New Market, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	July 13, 67	Chester	Chestertown Ket. Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
[illegible] Clark	Easton Md	JUL 13 1967	[illegible]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09520

09522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
   c. LENGTH OF STAY IN 1b: 3 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge Maryland Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Dorchester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
   d. STREET ADDRESS: 409 Cemetery Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

09.1

63

I

3. **NAME OF DECEASED** (Type or print): First SAMUEL — Middle OSCAR — Last JENKINS

4. **DATE OF DEATH**: Month July — Day 12 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 13, 1882

9. AGE (In years last birthday): 84 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman-Retired

10b. KIND OF BUSINESS OR INDUSTRY: Seafood

11. BIRTHPLACE (State or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Jenkins

14. MOTHER'S MAIDEN NAME: Dulcina MacNamara

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
    (If yes give war or dates of service): - - -

16. SOCIAL SECURITY NO.: 212-16-7373A

17. **INFORMANT** Address: Mrs Louise Delaha, Cambridge, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 Wk.
    903.0
    DUE TO
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
    (b): Fracture neck right femur. — 15 days
    DUE TO
    (c):

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive heart failure ?

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Slipped and fell in his home.

20c. TIME OF INJURY Month, Day, Year: Hour ? o.m. p.m. 6/27/67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒ — 2

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Cambridge, Dor. Md.

09

21. I **certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

2

ACTUAL SIGNATURE: John Mace Jr M.D.

EXAMINER'S NAME (Type): John Mace Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 7/19/67

Address (Street, city, town, or county): Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 14 1967

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park

23d. LOCATION (City or Town) (County) (State): Cambridge, Maryland

24. FUNERAL DIRECTOR — ADDRESS: LeCompte Funeral Service, Cambridge, Maryland

25a. REC'D BY REGISTRAR DATE: JUL 21 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

Film #390 - 7/21/67 - MB -

Originally reported on regular death certificate
and should have been on M.E.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09521

CERTIFICATE OF DEATH

09523

1. **PLACE OF DEATH**
   a. COUNTY: DORCHESTER — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CAMBRIDGE
   c. LENGTH OF STAY IN 1b: 6 YEARS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): EASTERN SHORE STATE HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institutian: Residence before admission)
   a. STATE: Md. — b. COUNTY: CAROLINE
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROUTE 1, FEDERALSBURG
   d. STREET ADDRESS: Bridgeville Road
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First CHARLES — Middle WESLEY — Last JOHNSON

4. **DATE OF DEATH**: Month JULY — Day 5 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 10/13/~~07~~1906

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Haurs — Min.

10a. USUAL OCCUPATION (Give kind of wark dane during mast af warking life, even if retired): FARMER (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): ~~Md.~~ Sussex Co., Delaware

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: GEORGE JOHNSON

14. MOTHER'S MAIDEN NAME: BESSIE HOLDER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. **INFORMANT** Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Thrombosis	4 hours
DUE TO (b)	Arteriosclerosis	10 years
DUE TO (c)		

33.1X

Conditions, if any, which gave rise ta immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Nat While at wark [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 3/2, 1961, ta 7/5, 1967, thot (I) (we) last saw the deceased alive an 7/5 19 67, and that death accurred at 11 ~~or~~ A M, fram causes and an the date stated abave.

22a. SIGNATURE: C.F Barroso — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 7/5/67

22c. PHYSICIAN'S NAME (Type): C.F BARROSO MD

22d. ADDRESS: E.S.S.HOSPITAL, CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery

23d. LOCATION (City or Town) (County) (State): Near Federalsburg, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Frampton Funeral Home Federalsburg Md

25a. REC'D BY REGISTRAR DATE: JUL 7 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09522

CERTIFICATE OF DEATH

09524

1. **PLACE OF DEATH**
   a. COUNTY: DORCHESTER — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CAMBRIDGE
   c. LENGTH OF STAY IN 1b: 8 MONTHS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): EASTERN SHORE STATE HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD. — b. COUNTY: WORCESTER
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROUTE 3, BERLIN
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: EDWARD — Middle: — Last: JOHNSON

4. **DATE OF DEATH**: Month: JULY — Day: 7 — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] SEP.

8. DATE OF BIRTH: 9/3/[illegible]

9. AGE (In years last birthday): 59 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: DANIEL JOHNSON

14. MOTHER'S MAIDEN NAME: LIZZIE MARSHALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): -
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 219-07-[illegible]

17. **INFORMANT** Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Aspiration of stomach contents — INTERVAL BETWEEN ONSET AND DEATH:
    DUE TO (b): Uremia
    DUE TO (c):
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
    792x

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/4, 19 66 to 7/7, 1967, that (I) (we) last saw the deceased alive on 7/7 19 67, and that death occurred at 6:45 A.M. from causes and on the date stated above.

22a. SIGNATURE: Robert W. Rieckert M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: 7/7/67

22c. PHYSICIAN'S NAME (Type): Robert W. Rieckert

22d. ADDRESS: E.S.S. HOSPITAL, CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7-11-67

23c. NAME OF CEMETERY OR CREMATORY: New Bethel

23d. LOCATION (City or Town) (County) (State): Berlin Worc MD

24. FUNERAL DIRECTOR: Loretta B. Jolley — ADDRESS: Jolley's Funeral Home Jersey Rd. Rt #2 Salisbury

25a. REC'D BY REGISTRAR DATE: JUL 12 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09523

CERTIFICATE OF DEATH

09525

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Eastern Shore State Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 300 Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Virginia; Middle: Mae; Last: Johnson
4. DATE OF DEATH: Month: 7; Day: 8; Year: 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-13-97
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joshua Smullen
14. MOTHER'S MAIDEN NAME: XXXXXXXXXXX Martha Ann Tarr
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 212-03-4733 XXXXXXXXX
17. INFORMANT: Mrs. Madelyn E. Donaway, R.D. Address: Pittsville, Md
Eastern Shore State Hospital Medical Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (g), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
DUE TO (b): GENERALIZED ATHEROSCLEROSIS — 2YRS
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse last.
DUE TO (c):
H500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Poss. Hypothyroidism; Parkinson's Dis. Diabetes
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): N/A
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this haspitol) attended the deceased from 6-23-, 1965 to 7-8-, 1967 that (I) (we) last saw the deceased alive on 7-8- 1967, and that death accurred at M, from causes and on the date stated above.

22a. SIGNATURE: Edward
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: July 8, 1967
22c. PHYSICIAN'S NAME (Type): EDWARD LEWIS M.D.
22d. ADDRESS: E.S.S. Hosp., Cambridge, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 12, 1967
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland
24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, Salisbury, Maryland
25a. REC'D BY REGISTRAR DATE: JUL 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09524 09526

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: DORCHESTER	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CAMBRIDGE	c. LENGTH OF STAY IN 1b: LIFE	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): CAMBRIDGE MARYLAND HOSPITAL, INC.
2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE: MARYLAND	b. COUNTY: DORCHESTER	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE 09-1	d. STREET ADDRESS: 707 CORNISH DRIVE — e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
SYLVIA	PLATER	JOLLEY	JULY	10,	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
FEMALE	NEGRO		MARCH 8, 1934	33 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	----------	DORCHESTER CO., MD.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CLIFTON PLATER	MARY JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	-----	212-32-7536	ORWOOD JOLLEY	CAMBRIDGE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 27, 19 67, to July 10, 19 67 that (I) (we) last saw the deceased alive on ____ 19____, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22b. DATE SIGNED
J. Edwin Fassett		July 11, '67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
J. EDWIN FASSETT, M.D.	623 HIGH STREET CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	7/15/67	OLDFIELD	DORCHESTER CO., MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Frederick C. St. Clair	CAMBRIDGE, MD.	JUL 17 1967	J. Charles Jones

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09525

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09527

1. **PLACE OF DEATH**
   a. COUNTY: DORCHESTER — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS
   c. LENGTH OF STAY IN 1b: 6 MONTHS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: KENT
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN 14.2
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: PATRICIA — Middle — Last: JONES

4. **DATE OF DEATH**: Month: JULY — Day: 12 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 03-18-19

9. AGE (In years last birthday): 48 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): KANSAS

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES R. JONES

14. MOTHER'S MAIDEN NAME: ~~DOROTHY CUMMINGS~~ Ysidra Ellis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: — —

17. **INFORMANT** Address: RECORDS OF THE EASTERN SHORE STATE HOSPITAL

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive aspiration of
DUE TO (b): stomach content
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 921.9
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizo phrenic reaction (clinically)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robt W Reed M.D.

EXAMINER'S NAME (Type): Robt H. Rieckard

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county): E-New Market

22. DATE SIGNED: 7-13-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 15/67

23c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery

23d. LOCATION (City or Town) (County) (State): Chestertown Kent Md.

24. FUNERAL DIRECTOR: Marvin C. Williams ADDRESS: Chestertown Md.

25a. REC'D BY REGISTRAR DATE: JUL 18 1967

25b. REGISTRAR'S SIGNATURE: Charles Yingling

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09526

CERTIFICATE OF DEATH

09528

1. PLACE OF DEATH
a. COUNTY: DORCHESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE
c. LENGTH OF STAY IN 1b: 1 MON.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CAMBRIDGE MARYLAND HOSPITAL, INC.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: DORCHESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE
d. STREET ADDRESS: 810 PHILLIPS STREET
e. IS RESIDENCE ON A FARM? YES [X] NO [X]

3. NAME OF DECEASED (Type or print): First ENOCH — Middle — Last LEE

4. DATE OF DEATH: Month JULY — Day 17 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: NEGROID

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: DEC. 25, 1890

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (County & State, or foreign country): DORCHESTER CO., MD.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: GEORGE LEE

14. MOTHER'S MAIDEN NAME: ANNIE SEYMORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): -----

16. SOCIAL SECURITY NO.: 217-07-3774A

17. INFORMANT — Address: HATTIE LEE — CAMBRIDGE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Leukemia
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 3, 1967, to July 17, 1967, that (I) (we) last saw the deceased alive on July 17, 1967, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: J. Edwin Fassett

M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: July 19, 1967

22c. PHYSICIAN'S NAME (Type): J. EDWIN FASSETT, M.D.

22d. ADDRESS: 623 HIGH STREET CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/22/67

23c. NAME OF CEMETERY OR CREMATORY: MALONES

23d. LOCATION (City or Town) (County) (State): MADISON DOR. MD.

24. FUNERAL DIRECTOR: Frederick C. Phillips

ADDRESS: CAMBRIDGE, MD.

25a. REC'D BY REGISTRAR DATE: JUL 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09527

CERTIFICATE OF DEATH

09530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Crocheron
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EVELYN — Middle SINCLAIR — Last MILLS

4. DATE OF DEATH: Month July — Day 6 — Year 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 26, 1909

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Sinclair

14. MOTHER'S MAIDEN NAME: Mary McNamara

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): - - -

16. SOCIAL SECURITY NO.: 212-14-4215

17. INFORMANT: Mr. Russell H. Mills, Crocheron, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Marked acute and chronic infection — 3 days
DUE TO
(c) of gall bladder, post-operative — Unknown

585 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): cholecystectomy and splenectomy (hypersplenism)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Hypertensive cardiovascular disease

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 1, 19 67 to July 6, 19 67 that (I) (we) last saw the deceased alive on July 6 19 67, and that death occurred at 8 PM, from causes and on the date stated above.

22a. SIGNATURE: Lewis M Burdette — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8 July 67

22c. PHYSICIAN'S NAME (Type): Lewis M. Burdette

22d. ADDRESS: 4 Aurora St Cambridge, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 9 1967

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park

23d. LOCATION (City or Town) (County) (State): Cambridge, Maryland

24. FUNERAL DIRECTOR — ADDRESS: LeCompte Funeral Service, Cambridge, Maryland

25a. REC'D BY REGISTRAR DATE: JUL 10 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09528

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09531

1. PLACE OF DEATH
a. COUNTY Dorchester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Vienna
c. LENGTH OF STAY IN 1b Instant
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Rt. 50 1 mile East of Vienna

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE District Columbia COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. STREET ADDRESS 4701 Western Avenue, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First PAULINE Middle MARIE Last MUIR

4. DATE OF DEATH Month July Day 28 Year 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 3-31-1899

9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fitter-

10b. KIND OF BUSINESS OR INDUSTRY Julius Garfinckel & Co.

11. BIRTHPLACE (State or foreign country) France

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown - Gigon

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - - - -

16. SOCIAL SECURITY NO. - - -

17. INFORMANT Address Bethesda Md.
Mrs. Colette D. Eaton, 6701 Renita Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Crushing injury of chest
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) head on collision Rt 50 near Vienna

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7-28 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street

20f. (City or town) Vienna (County) Dorchester (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Carl W. Rieckert M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) Carl W. Rieckert Address (Street, City, Town, or county) E-New Market, Md

22. DATE SIGNED 7-28-67

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 8-1-1967

23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.

23d. LOCATION (City or Town) Arlington (County) (State) Va.

24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisc. Ave. N.W. Wash. D.C.

25a. RECD BY REGISTRAR DATE AUG 2 1967

25b. REGISTRAR'S SIGNATURE J. Charles Juegel

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09529 09532

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Cambridge
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Wingate

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Cambridge
d. STREET ADDRESS: Wingate
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GERTIE Middle: ELLEN Last: PARKS

4. DATE OF DEATH: Month: July Day: 30, Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 2, 1876

9. AGE (In years last birthday): 91 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Tall

14. MOTHER'S MAIDEN NAME: unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service): - - -

16. SOCIAL SECURITY NO.: unk

17. INFORMANT: Mr. Albert Parks, Wingate, Maryland 21675 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 YEARS
DUE TO
(b):
DUE TO
(c):
4341
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/15, 1960, to 7/30, 1967, that (I) (we) last saw the deceased alive on 31 DEC 1965, and that death occurred at 7A. M, from causes and on the date stated above.

22a. SIGNATURE: W. E. Gunby Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/31/67

22c. PHYSICIAN'S NAME (Type): W. E. GUNBY JR.

22d. ADDRESS: CAMBRIDGE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 2, 1967

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park

23d. LOCATION (City or Town) (County) (State): Cambridge, Maryland

24. FUNERAL DIRECTOR: LeCompte Funeral Service, Cambridge, Maryland — ADDRESS

25a. REC'D BY REGISTRAR DATE: AUG 4 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09530 09533

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn): Rural-Cambridge
d. STREET AOORESS: Maple Dam Road, RFD #2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First SAMUEL Middle C. Lost PAYSINGER

4. DATE OF DEATH: Month July Doy 7 Year 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] OIVORCED [ ]
8. DATE OF BIRTH: Dec. 11, 1892
9. AGE (In yeors last birthday): 74 yrs.
IF UNDER 1 YEAR: Months Ooys
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumberman-Retired
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (County & State, or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Paysinger
14. MOTHER'S MAIDEN NAME: Ada Shigh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service): - - -
16. SOCIAL SECURITY NO.: unk
17. INFORMANT Address: Mrs. Samuel C. Paysinger, Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF OEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEOIATE CAUSE (o): Arteriosclerotic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 16 days
DUE TO
Conditions, if any, which gove rise to immediate couse (o), stoting the underlying couse last.
(b): Coronary Heart Disease — 3 yrs
DUE TO
(c): Myocardial Infarction — 7 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20o. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURREO. (Enter noture af injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I **certify** that (I) (this hospital) attended the deceased from 6/21/67, 19 ___, to 7/7/67, 19 ___, that (I) (we) last saw the deceased alive on 7/7/67 19 ___, and that death occurred at 6 p.m. M, from causes and on the date stoted above.

22o. SIGNATURE: Lawrence Maryanov — M.D. ATTENDING PHYS. [ ] MED. DIRECTOR [✓] STAFF PHYS. [ ]
22b. DATE SIGNED: 7/8/67
22c. PHYSICIAN'S NAME (Type): Lawrence Maryanov
22d. ADDRESS: Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 10 1967
23c. NAME OF CEMETERY OR CREMATORY: East New Market Cemetery
23d. LOCATION (City or Town) (County) (Stote): East New Market, Maryland

24. FUNERAL DIRECTOR ADDRESS: LeCompte Funeral Service, Cambridge, Maryland
25a. REC'D BY REGISTRAR DATE: JUL 10 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09531

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09534

1. PLACE OF DEATH
   a. COUNTY: DORCHESTER — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CAMBRIDGE
   c. LENGTH OF STAY IN 1b: 52 YEARS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): EASTERN SHORE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: CECIL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
   d. STREET ADDRESS: -
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BENJAMIN — Middle: — Last: PRICE

4. DATE OF DEATH: Month: JULY — Day: 3 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 25, ~~1887~~ 1886

9. AGE (In years last birthday): 80 ~~81~~ yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): ~~Baltimore~~ Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: BENJAMIN PRICE

14. MOTHER'S MAIDEN NAME: ~~Linda~~ JONES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None.

17. INFORMANT — Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	TERMINAL PNEUMONIA	2 DAYS
DUE TO (b)	FRACTURE NECK R. FEMUR	3 DAYS
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 904.7

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): FELL IN HOSPITAL

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 6/30/67 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOSPITAL

20f. (City or town) (County) (State): CAMBRIDGE DOR. MD.

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.

EXAMINER'S NAME (Type): JOHN MACE JR.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): CAMBRIDGE, MD.

22. DATE SIGNED: 7/3/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July, 7, 1967

23c. NAME OF CEMETERY OR CREMATORY: St. Stephens Cemetery.

23d. LOCATION (City or Town) (County) (State): Earleville, Cecil, Md.

24. FUNERAL DIRECTOR — ADDRESS: Edward Fellows — Cecilton, Md.

25a. REC'D. BY REGISTRAR DATE: JUL 6 1967

25b. REGISTRAR'S SIGNATURE: Edward Judge

VR A15ME (5)
6M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09532

CERTIFICATE OF DEATH

09536

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 1100 Race Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 1100 Race Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katie — Middle: Rosalie — Last: Schaffer

4. DATE OF DEATH: Month: July — Day: 24 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 29, 1881

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frederick Hahn

14. MOTHER'S MAIDEN NAME: Frieda

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Charles R. Schaffer, Address: 1100 Race Street, Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Food Aspiration — INTERVAL BETWEEN ONSET AND DEATH: 3 Minutes
334X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Advanced Senility
DUE TO (c): Cerebral Vascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-29, 1967, to 7-24, 1967, that (I) (we) last saw the deceased alive on 7-17, 1967, and that death occurred at 1:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard G. Bilodeau — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-25-67

22c. PHYSICIAN'S NAME (Type): RICHARD G. BILODEAU

22d. ADDRESS: CITY OFFICE BLDG., CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 27, 1967

23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery

23d. LOCATION (City, town or county) (State): Pikesville, Md.

24. FUNERAL DIRECTOR: Kenneth R. Thomas — ADDRESS: Cambridge, Md.

25a. RECD BY REGISTRAR — DATE: JUL 31 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

09533

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09537

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge, Md. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 2402 Woodbury Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: Ann — Last: Schiavone

4. DATE OF DEATH: Month: July — Day: 28 — Year: 1967

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 27, 1963

9. AGE (In years last birthday): 4 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Matthew A. Schiavone

14. MOTHER'S MAIDEN NAME: Vera Mae Kiddwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Cambridge Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial injuries — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Multiple fractures skull
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Passenger in auto in head on collision.

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 12.30PM 7-28-67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) Vienna (County) Dor. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.

EXAMINER'S NAME (Type): John Mace Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 7/29/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2 AUGUST 1967

23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY

23d. LOCATION (City or Town) WASHINGTON (County) (State) DC.

24. FUNERAL DIRECTOR — ADDRESS: Rinaldi Funeral Home, Washington, D.C. 7400 Georgia Ave., N.W.

25a. REC'D BY REGISTRAR DATE: AUG 1 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09534

09538

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 40 Min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 2402 Woodbury Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Vera — Middle: Mae — Last: Schiavone

4. DATE OF DEATH: Month: July — Day: 28, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 10 1927

9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WASHINGTON D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LAWRENCE KIDWELL

14. MOTHER'S MAIDEN NAME: ELIZABETH (UNK.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT — Address: Cambridge Md. Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial injuries
DUE TO
(b): Multiple skull fractures
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 hour

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in car in head on collision

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m.: 12.30PM 7/28/67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): Vienna, Dor. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.

EXAMINER'S NAME (Type): John Mace Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 7/29/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2 AUGUST 1967

23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY

23d. LOCATION (City or Town) (County) (State): WASHINGTON DC.

24. FUNERAL DIRECTOR: Rinaldi Funeral Home, Washington, D.C.
ADDRESS: 7400 Georgia Ave. N.W.

25a. RECD BY REGISTRAR DATE: AUG 1 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Juggs

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forworded to the Chief Medicol Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09535 09539

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Cambridge
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cason's Neck Road, RFD No. 3

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Dorchester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Cambridge
   d. STREET ADDRESS: Cason's Neck Road, RFD No. 3
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First VERNIE — Middle ALLEN — Last SEWARD

4. **DATE OF DEATH**: Month July — Day 28 — Year 19 67

5. **SEX**: Male

6. **COLOR OR RACE**: White

7. **MARRIED** ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. **DATE OF BIRTH**: July 15, 1892

9. **AGE** (In years last birthday): 75 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Carpenter-Waterman

10b. **KIND OF BUSINESS OR INDUSTRY**: General-Seafood

11. **BIRTHPLACE** (State or foreign country): Dorchester Co., Maryland

12. **CITIZEN OF WHAT COUNTRY?**: USA

13. **FATHER'S NAME**: Thomas Edward Seward

14. **MOTHER'S MAIDEN NAME**: Susie Emily Hubbard

15. **WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
    (If yes give war or dates of service): - - -

16. **SOCIAL SECURITY NO.**: unk

17. **INFORMANT**: Mrs. V. A. Seward, RFD #3, Cambridge, Md. — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Coronary occlusion
    DUE TO (b):
    DUE TO (c):
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
    INTERVAL BETWEEN ONSET AND DEATH: Instant

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. **WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.

EXAMINER'S NAME (Type): John Mace Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. **DATE SIGNED**: 7/28/67

Address (Street, city, town, or county): Cambridge, Md.

23a. **BURIAL, CREMATION, REMOVAL** (Specify): Burial

23b. **DATE THEREOF**: July 30 1967

23c. **NAME OF CEMETERY OR CREMATORY**: Dail Family Cemetery

23d. **LOCATION** (City or Town) (County) (State): RFD #3, Cambridge, Maryland

24. **FUNERAL DIRECTOR**: LeCompte Funeral Service, Cambridge, Maryland — ADDRESS

25a. **REC'D BY REGISTRAR** DATE: AUG 1 1967

25b. **REGISTRAR'S SIGNATURE**: Charles Yingst

1

09536

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09541

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremotion, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eastern Shore State

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Easton
d. STREET ADDRESS: Bay 143 Rt 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertha — Middle: W. — Last: Slaughter

4. DATE OF DEATH: Month: 7 — Day: 19 — Year: 1967

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 06-01-01

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Dor. Md

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dates of service):

16. SOCIAL SECURITY NO.: 214-16-4212A

17. INFORMANT — Address: Reuds E.S.S.H.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Tumor of ascending colon — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gove rise to immediate cause (a), stoting the underlying couse last.
230 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 13, 1967, to July 19, 1967, that (I) (we) last saw the deceased alive an July 19 1967, and that death accurred at 3:30 p M, fram causes and an the date stated abave.

22a. SIGNATURE: Carlos F Ramos — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-19-67

22c. PHYSICIAN'S NAME (Type): CARLOS F. BARROSO

22d. ADDRESS: Hurlock Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-22-67

23c. NAME OF CEMETERY OR CREMATORY: Ivytown

23d. LOCATION (City or Town) (County) (State): Easton Talbot Md.

24. FUNERAL DIRECTOR — ADDRESS: George H Dashiell Easton Md

25a. RECD BY REGISTRAR DATE: JUL 21 1967

25b. REGISTRAR'S SIGNATURE: Clarence Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09537 09540

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: DORCHESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): CAMBRIDGE MARYLAND HOSPITAL, INC.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: DORCHESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LINKWOOD, MD.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILHELMINA — Middle BAILEY — Last STANLEY

4. DATE OF DEATH: Month JULY — Day 10, — Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: FEB. 2, 1909
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): WICOMICO CO., MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BAILEY
14. MOTHER'S MAIDEN NAME: ELIZABETH BAILEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give wor or dotes of service): *** ***
16. SOCIAL SECURITY NO.: 214-07-8809
17. INFORMANT: A. B. STANLEY — Address: LINKWOOD, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO (b): Coronary heart disease
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 20, 19 67, to July 10, 19 67, that (I) (we) last saw the deceased alive on July 10, 19 67, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: John Fassett
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/14/67
22c. PHYSICIAN'S NAME (Type): J. EDWIN FASSETT, M. D.
22d. ADDRESS: 623 HIGH STREET CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7/15/67
23c. NAME OF CEMETERY OR CREMATORY: AIREYS
23d. LOCATION (City or Town) (County) (State): AIREYS DORCHESTER MD.

24. FUNERAL DIRECTOR: Frederick C. DeVaris — ADDRESS: CAMBRIDGE, MD.
25a. REC'D BY REGISTRAR DATE: JUL 17 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09538

CERTIFICATE OF DEATH

09542

1. **PLACE OF DEATH**
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Cambridge
c. LENGTH OF STAY IN 1b: 18 yr. 11 Mon. 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eastern Shore State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Lillie — Middle: DURHAM — Last: Taylor

4. **DATE OF DEATH**: Month: July — Day: 14 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 10, 1897

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Durham

14. MOTHER'S MAIDEN NAME: Ella Swift

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. **INFORMANT**: Medy Records. Address: Eastern Shore State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Senil cachexia.
DUE TO
4500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome, Arteriosclerosis. Decubitum ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 11, 19 48, to July 14, 1967, that (I) (we) last saw the deceased alive an July 14 1967, and that death occurred at 5:30 PM, from causes and an the date stated abave.

22a. SIGNATURE: Carlos F Barroso — M.D. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: July 14 1967

22c. PHYSICIAN'S NAME (Type): CARLOS F. BARROSO MD

22d. ADDRESS: Hurlock Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7-16-1967

23c. NAME OF CEMETERY OR ~~CREMATORY~~: WESSELL'S CEMETERY

23d. LOCATION (City or Town) (County), (State): MEARS, ACCOMACK, VIRGINIA

24. FUNERAL DIRECTOR: Robert H. Watson — ADDRESS: Pocomoke City, Md.
ROBERT H. WATSON

25a. REC'D BY REGISTRAR DATE: JUL 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09539 09543

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Dorchester
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 47 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Cambridge-Md. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 710 Glasgow St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel; Middle: Laverne; Last: Turner

4. DATE OF DEATH: Month: July; Day: 10; Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Jan. 29, 1917

9. AGE (In years last birthday): 50 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress.

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (County & State, or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Tilman

14. MOTHER'S MAIDEN NAME: Ethel Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-07-8295

17. INFORMANT: Wayne V Turner Address: Rt. 1, Hebron Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardio Vascular Disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-16-66, 19__, to 7-10-67, 19__, that (I) (we) last saw the deceased alive on 7-3-15-67 19__, and that death occurred at 5:00AM from the causes and on the date stated above.

22a. SIGNATURE: Albert E Bunker M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-11-67

22c. PHYSICIAN'S NAME (Type): ALBERT E. BUNKER, M. D.

22d. ADDRESS: 200 Md.Ave., Cambridge, Md. 21613

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 12 1967

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Mem Park

23d. LOCATION (City, town or county) (State): Cambridge Md.

24. FUNERAL DIRECTOR: Kenneth R Horne Jr. ADDRESS: Cambridge Md.

25a. REC'D BY REGISTRAR DATE: JUL 17 1967

25b. REGISTRAR'S SIGNATURE: Thomas Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09540

CERTIFICATE OF DEATH

09544

1. PLACE OF DEATH
a. COUNTY: Dorchester
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 55 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 108 Willis Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 108 Willis Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Myrtle Middle: Booze Last: Vickers

4. DATE OF DEATH: Month: July Day: 11 Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 5, 1892

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homamekare

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Lakesvill, Dor., Co.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert O. Booze

14. MOTHER'S MAIDEN NAME: Annie Mills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-12-1053

17. INFORMANT: Address: 108 Willis Street
Bradford A. Vickers, Sr., Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): METASTATIC CARCINOMA OF LIVER — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

1561

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): HYPERTENSIVE CARDIO VASCULAR DISEASE - DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-9-50, 19__, to 7-11-67, 19__, that (I) (we) last saw the deceased alive on 7-6-67, 19__, and that death occurred at 7:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Albert E. Bunker

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-12-67

22c. PHYSICIAN'S NAME (Type): ALBERT E. BUNKER, M. D.

22d. ADDRESS: 200 Md. Ave., Cambridge, Maryland 21613

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 14, 1967

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial

23d. LOCATION (City, town or county) (State): Park, Cambridge, Md.

24. FUNERAL DIRECTOR: Kenneth R. Thomas

ADDRESS: Cambridge, Md.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE: JUL 17 1967

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09541

CERTIFICATE OF DEATH

09545

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: DORCHESTER
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE (RURAL)
c. LENGTH OF STAY IN 1b: 18 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): EASTERN SHORE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PARSONSBURG
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ISAAC Middle SAMUEL Last WHITE

4. DATE OF DEATH: Month JULY Day 21 Year 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 06-26-89

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS WHITE

14. MOTHER'S MAIDEN NAME: MARGARET SEARS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): UNKNOWN / NO

16. SOCIAL SECURITY NO.: 217-34-0424

17. INFORMANT Address: RECORDS OF THE EASTERN SHORE STATE HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis, Right base — INTERVAL BETWEEN ONSET AND DEATH: 12 days
DUE TO (b): Arteriosclerotic Cardiovas. Dis. — 18 mos.
DUE TO (c): —
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse last.
H221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot ☐ (this hospitol) attended the deceased from 7-3- , 1967 to 7-21- , 1967, that (I) (we) last saw the deceased alive on 7-21- 1967, and that death occurred at 1110 P M, from causes and on the date stoted above.

22a. SIGNATURE: Edward Lewis — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 7-21-67

22c. PHYSICIAN'S NAME (Type): EDWARD LEWIS M.D.

22d. ADDRESS: EASTERN SHORE STATE HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/25/1967

23c. NAME OF CEMETERY OR CREMATORY: PARSONSBURG CEM

23d. LOCATION (City or Town) (County) (State): PARSONSBURG WIC. MD.

24. FUNERAL DIRECTOR: Hill Funeral Home ADDRESS: SALISBURY, MD

25a. REC'D BY REGISTRAR DATE: JUL 25 1967

25b. REGISTRAR'S SIGNATURE: Charles Yeager

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09542

09547

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: Dorchester MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Rhodesdale
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): R. F. D.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland b. COUNTY: Dorchester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rhodesdale (Rural)
   d. STREET ADDRESS: R. F. D.
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Stephen Middle: Winfield Last: Wongus

4. **DATE OF DEATH**: Month: July Day: 12, Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] Separated [X]

8. DATE OF BIRTH: March 17, 1906

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Day Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fred Camper

14. MOTHER'S MAIDEN NAME: Willie Wongus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-26-3020

17. **INFORMANT** Address: Mrs. Flora Stanley, Rhodesdale, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
   DUE TO
   Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
   (b) DUE TO
   (c)

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** thot I took chorge of the remoins described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], ond in my opinion depth resulted from: Naturol couses [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Mace M.D.

EXAMINER'S NAME (Type): John Mace Jr. M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22. DATE SIGNED: 7/14/67

Address (Street, city, town, or county): Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 16, 1967

23c. NAME OF CEMETERY OR CREMATORY: Cross Roads Cemetery

23d. LOCATION (City or Town) (County) (State): Vienna, Dorchester, Md.

24. FUNERAL DIRECTOR: Frompton Funeral Home ADDRESS: Federalsburg, Md.

25a. REC'D BY REGISTRAR DATE: JUL 17 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones